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EXPERIENCE REPORT

Unveiling the design of therapeutic nursing in mental health: an experience report

Desvendando o projeto terapêutico de enfermagem em saúde mental: um relato de experiência

Desvendando el proyecto terapéutico de enfermería en salud mental: un relato de experiencia

Marcela Pimenta Muniz ¹, Cláudia Mara de Melo Tavares ², Ândrea Cardoso de Souza ³, Carolina Keiko Rocha Pacheco ⁴, Lirys Figueiredo ⁵

ABSTRACT

Objective: To build a therapeutic project with emphasis on nursing care, mental health perspective. Was prepared during the patient's stay in a psychiatric hospital in the city of Niterói, state of Rio de Janeiro (RJ). **Method:** Through a job done collectively between nurses and nursing students, led a reflection on the care that it needs to be achieved by the nursing staff in the psychiatric reform, described the experience report. So, we made a discussion group for the preparation of the plan of care for the patient, considering the peculiarities of the case study in question. **Results:** addressed the identification, summary, history, pathology and treatment plan for nursing care. **Conclusion:** it is necessary for practitioners and nursing students gather around the subject with mental distress, and allow yourself to learn to take care of it according to its history. **Descriptors:** Psychiatric nursing, Mental health, Schizophrenia, Nursing care.

RESUMO

Objetivo: construir um projeto terapêutico com ênfase nos cuidados de enfermagem, na perspectiva da saúde mental. Foi elaborado durante a internação do paciente em um hospital psiquiátrico do município de Niterói, estado do Rio de Janeiro (RJ). **Método:** através de um trabalho feito coletivamente entre enfermeiros e acadêmicos de enfermagem, provocou-se uma reflexão quanto ao cuidado que é preciso que seja alcançado por parte da equipe de enfermagem no contexto da reforma psiquiátrica, descrito pelo relato de experiência. Assim, foi feito um grupo de discussão para a elaboração do plano de cuidados para o paciente, considerando-se as peculiaridades do caso clínico em questão. **Resultados:** abordou-se a identificação, súmula, histórico, patologias e projeto terapêutico para os cuidados de enfermagem. **Conclusão:** é preciso que os profissionais e acadêmicos de enfermagem aproximem-se do sujeito portador de sofrimento mental e permitam-se aprender a cuidar deste de acordo com sua história. **Descritores:** Enfermagem psiquiátrica, Saúde mental, Esquizofrenia, Cuidados de enfermagem.

RESUMEN

Objetivo: construir un proyecto terapéutico con énfasis en los cuidados de la enfermería, en la perspectiva de la salud mental. Fue elaborado durante la internación del paciente en un hospital psiquiátrico del municipio de Niterói, estado de Rio de Janeiro (RJ). **Método:** a través de un trabajo hecho colectivamente entre enfermeros y académicos de enfermería se provocó una reflexión cuanto al cuidado que es preciso que sea alcanzado por parte del equipo de enfermería en el contexto de la reforma psiquiátrica, descrito por el relato de experiencia. Así, fue formado un grupo de discusión para la elaboración del plano de cuidados para el paciente, considerándose las peculiaridades del caso clínico en cuestión. **Resultados:** se abordó la identificación, hoja de anotación, histórico, patologías y proyecto terapéutico para los cuidados de enfermería. **Conclusión:** es preciso que los profesionales y académicos de enfermería se aproximen del sujeto portador de sufrimiento mental y permitan aprender a cuidar de este de acuerdo con su historia. **Descriptor:** Enfermería psiquiátrica, Salud mental, esquizofrenia, Atención de enfermería.

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INTRODUCTION

The current study relates to an experience report with emphasis on the collective development of the treatment plan, on perspective on mental health. It was prepared during a patient hospitalization in a psychiatric hospital in the city of Niterói-RJ. The main objective was the elaboration of nursing care plan, from an approximation of the life history of this patient. This case study was prepared by a working done collectively, provoking a reflection about the care that is possible and that it must be achieved by the nursing team in the psychiatric reform context. It is extremely valuable for nursing, for the patients and for the research that studies can be developed regarding the practice of mental health nursing, seeking to increase the knowledge in this field of care. So, this experience report serves as a guiding tool for those who already work in this area, as well as the academics, who were able to participate actively in the development of the treatment plan from the experience they had with this same patient and through literature searches. It is worth noting that, during this current research, also sought to emphasize the care needed for the patient's body, regarding clinical pathologies, beyond the care related to mental health.

The Brazilian psychiatric reform movement seeks to deconstruct reality asylum - beyond "Collapse of the madhouse walls" in a physical sense. Therefore, it is possible that operates in transformations of an entire culture that supports violence, discrimination and the craziness imprisonment. The first step would be to renounce the pursuit of healing and take as object existence-suffering. Health begins, then, to be understood no more from welfare defined parameters by biomedical principles, but as production of possible life and with regard to the subjects in their singularities in different sociability spaces and solidarity in circulating.

METHODOLOGY

This is a qualitative research, an exploratory kind. In a psychiatric hospital in the city of Niterói-RJ, a discussion group was made for the preparation of the care plan for the patient, considering the peculiarities of the clinical case in question, being described in this current article as an experience report.

The discussion group was composed by the authors of this work: Therefore, 01 nurse, 02 university professors, 02 Nursing Academics participated in the survey - who now are nurses.

The following issues were considered:

- What is the life history of this patient?
- What is your health status?
- What are their main demands in relation to health services?

- What treatment plan should be applied in relation to nursing?

Therefore, from problem-solving questions, grounded in relevant theoretical frameworks, was possible for us to make a plan of care, with emphasis on mental health nursing for the patient in question.

Theoretical Reference

The Psychiatric Reform

The Psychiatric Reform process has been built in Brazil for several years and has as one of its main pillars the deinstitutionalization. The deinstitutionalization is considered here as deconstruction of knowledge and psychiatric practice, perspective that underlies the psychiatric reform movement and mental health policy in Brazil, inspired on the proposal of the Italian democratic psychiatry.¹

This deinstitutionalization version is characterized by epistemological critique to medical psychiatric knowledge in which the sense of citizenship beyond exceeds the universal value to put in question the own mental illness concept which determines limits on the citizen rights.²

Health begins, then, to be understood no more from welfare defined parameters by biomedical principles, but as production of possible life and with regard to the subjects in their singularities in different sociability spaces and solidarity in circulating. And this should not be an end in itself, but as a mean of living life.³

Tangent to this, there is the need to make real to the nursing professionals this knowledge of psychiatric reform and the innovation practices she suggests. The scientific nursing is still anchored in a cause-effect positive paradigm which seeks for the homogenization (the “the cake recipe”) for the action and the design mode of illness and care.

Acquired cataract

The acquired cataract is the blurring or slowly progressive visual loss, often for months to years, affecting one or both eyes. The main detected signal during physical examination is the clouding of the lens (ocular structure which is usually transparent). The specific symptoms are based on the specific location and density of the opacification lens. The most common etiology is related to age.⁴

In some cases surgical treatment is indicated, to improve visual function in patients with symptomatic visual impairment and surgical therapy for eye disease - for example glaucoma or uveitis. For monitoring, unless there is a further secondary complication beyond the cataracts - for example, glaucoma, quite rare - an isolated cataract does not require urgent intervention.⁴

Glaucoma

Glaucoma is an intraocular structural damage resultant from elevated intraocular pressure. It is caused by obstruction of the outflow of aqueous humor. Without treatment, the disorder can cause blindness.⁵

The disorder is initially free of symptoms. The change of peripheral vision is the first sign. This progresses and can cause loss of central vision. Pain happens later.⁶

Glaucoma for crystalline particles, is caused by a crystalline material, released by trauma or surgery, blocking the drainage channels of the aqueous stream. The main symptoms are pain, blurred vision, red eye, tearing and photophobia.

For treatment, according to the literature, is indicated the use of topic beta-blocker, topical corticosteroids and ciclopegic topic.

Schizophrenia

The schizophrenia (F20) is today one of the major public health problems, requiring large investments in the health system and causing distress to the patient and his family.

Despite the low incidence, is a disease of long duration, builds up, over the years, a considerable number of people with this disorder, with different degrees of impairment and needs.

Usually characterized by fundamental distortions, thinking and perception characteristics and by inappropriate or blunted affect. A clear conscience and intellectual ability are visually maintained although certain cognitive deficits may arise in the course of time. Involves, thus, the most basic functions that give the person a sense of individuality, uniqueness and direction of herself.⁷ The thoughts, feelings and the most intimate acts are felt to be known or shared by others. Natural or supernatural forces influence the individual's thoughts and actions. The patient may see himself as the pivot of all that happens. Hallucinations, especially hearing, are common and can comment on the patient's behavior and thoughts.⁷

Perception is frequently disturbed. In disorder characteristic of schizophrenic thought, daily peripheral and irrelevant aspects that are inhibited in normal attitude, are brought to the foreground. Interruptions and interpolarizations are assiduous in the thought course. Furthermore, ambivalence and volition disturbance may appear as inertia, negativism or stupor.⁷

Specifically in Residual Schizophrenia (F20.5), there is a chronic stage in the developing a schizophrenic disorder, in which there is a clear progression of an early stage to a later stage characterized by "negative" symptoms of long duration, although not necessarily irreversible.

In this case, schizophrenic "negative" symptoms are prominent, that is, psychomotor retardation, hypoactivity, blunted affect, passivity and lack of initiative, poverty of the quality or speech content, poor nonverbal communication through facial expression, self-care and poor social performance.⁷

One of the diagnostic criteria is also the occurrence of a period of at least 1 year during which the intensity and frequency of symptoms flowering, such as delusions and hallucinations, were minimal or substantially reduced and the "negative" schizophrenic syndrome was present.⁴

RESULTS AND DISCUSSION

Patient Identification

Patient ARS. At the moment, he is 68 years old. It is male. He was admitted in a psychiatric hospital in Niterói-RJ.

Docket

Lucid patient, oriented. Thought with preserved form as well as the course, with persecutory delusions (says that people want to harm him on several occasions) and greatness (says that is retired as an FBI investigator) suicidal ideation, hearing hallucinations and visual pseudo-hallucinations. Its comorbidities are: Systemic Arterial Hypertension (SAH), cataracts and glaucoma.

Patient's history

He lives in Niterói alone, in a rented room, where there is only one mattress, unfurnished. Without family support. He says he has three children, but he has no contact with them for many years. He says he has no interest in resuming contact with the children "because they don't care"(SIC). He says he has been married to the mother of his children for 40 years, and that they got separated because they fought a lot and they wanted different things(SIC).

Patient with longstanding psychiatric history. He went through several psychiatric hospitalizations and electroconvulsive therapy sessions. He does irregular treatment in outpatient mental health. Has brought after playing in front of a car in an attempt to self-annihilation. Wearing his own clothes, in regular hygiene status, with no bruises or fractures. He uses a cane to help him in locomotion, and sunglasses. He demonstrates difficulty on walking, due to the large decrease in visual acuity (bilateral visual deficit). He Responds questions promptly, coherently. But rather modulates the tone of voice. Complains of fear and he says he "wanted to die".

He feels persecuted, threatened by people who do not tell him who they are. He says "they take advantage of me because I cannot see... They come into my house saying that will help me, but they take advantage because I cannot see and take my money".

He reports that, on one occasion, a man put him on a car to "harm him" (SIC), but he does not explain in greater details.

He says how difficult it is when he tries to buy something "people give me the wrong change, missing money, and I don't realize if someone around doesn't tell me".

Refers suicidal ideation "I do not want to live anymore...I'm useless... blind like this I cannot do anything alone". He says that, for him, "life has no meaning". Furthermore, refers listening hallucinatory voices imperative inveigh him, decrease him and send him kill himself. He complains: "I'm afraid of voices, and I'm afraid that something bad happens to me because I cannot see... I am very limited, my daughter". He tells about his difficulty of

leaving home. He says about the difficulty to lead through the days and nights without any occupation "locked at home, alone, with nothing to occupy me, with no one to help me". HE says he doesn't go to his psychiatrist for fear of being hit or miss. He reports that he doesn't make proper use of psychiatric medications and hypotensive due to the difficulty to know if he is taking the medicine (for not seeing the medicine names). The patient can not even eat properly, because, according to him, has no access to food nor the preparation of any type of food, due the impaired visual acuity. He seems to be sad, with depressed mood. We offer the patient accompany him to the balcony of the SRI. We realized that he had the interest to stay on the porch, but he was insecure, something suspicious of us. However, with greater proximity and therapeutic listening time on our part, he asked to stay on the porch for a few minutes with us, demonstrating satisfaction on being outdoors, talking to us into another space.

He said "it is good to be here on the porch... I'm listening to the birds and feeling fresh air "(SIC).

He referred pain on the right hand fingers (caused by trying to kill himself playing in front of cars).

Patient has a high degree of dependence o perform the daily living activities (DLA) and also to adhere to psychotherapeutic treatment, mainly due to visual impairment.

Therapeutic nursing project

- Make the nursing interview for the ocular examination;
- Determine if the patient has a disease history, ocular trauma, diabetes, hypertension or ophthalmic surgery;
- Determine reasons for the patient's visual complaints;
- Ask if they feel pain, photophobia, burning, itching;
- Investigate the presence of blurred vision, diplopia, excessive tearing or secretions, perception of a 'film' on the vision field, flies, bright lights (scotomas) or halos around lights;
- Determine if there is a family history of eye disorders or diseases;
- Ask the patient if he wears glasses or contact lenses, and frequency of use;
- Determine when was the last eye appointment;
- Forward to ophthalmologic, in case he has not yet been started;
- Provide pain relief, maintaining soft lighting ambient, considering that in many ocular diseases light causes pain;
- • Administer analgesics to assist in reducing pain, as medical as prescription;
- Perform relief from fear and anxiety, explaining the diagnosis and treatment plan for the patient, providing him a sense of participation;
- Facilitate reduction of sensory deprivation, reorienting it periodically to reality and reassuringly with explanations and information about the environment that he can not see clearly, preventing, thus, perception distortions, with an improper behavior or lost of position sense;
- Encourage stress coping mechanisms and socialization;

- Perform health education about the homecare considerations and on ophthalmological adequate treatment, promoting self-care activities;
- Observe for blood pressure measurement and for signs and symptoms of hypertensive crisis, such as dizziness, headache, nausea, neck pain, epistaxis and syncope;
- Implement biopsychosocial ratings in attention to the patient's cultural characteristics;
- Advise the patient about the characteristics of the pathologies, treatment and the available resources;
- Promote and manage, within the mental health, the disease effects, through education, research, providing a patient adequate counseling;
- Handle and coordinate care systems that incorporate the patient's needs, promoting an understanding and a better acceptance of the disease, which leads to better treatment adherence and a better social rehabilitation;
- Enable reintegration through socialization spaces;
- Promote the patient involvement in his self-care, regarding to medication, using, for example, containers recognizable by touch;
- Enter the patient in exchange experiences groups for blind people;
- Encourage the patient to rediscover their potential and activities that provide welfare;
- Enter the patient in a therapeutic workshop activities that are at your fingertips and that are of his interest, providing exploitation of other senses (especially touch and hearing);
- Find strategies that lead the patient resume the interest in food intake, using new places for meals and looking ways to enable the patient to feed himself, thereby providing, the self-care;
- Observe and record mistrust behavior, isolation, soliloquies, unmotivated laughs;
- Observe with the mood changes, and being closer to the patient in sad mood moments;
- Provide active listening, as a therapeutic instrument;
- Observe the recurrence of suicidal ideation and self-extermination imperative hallucinatory listen;
- Offer a safe environment, adapting the place due to their visual impairment, and keeping him away from sharp objects;
- Encourage the rehabilitation of the patient in a communitarian territory, like in the neighborhood, churches, neighborhood association, squares, public transport, basic health unit, market, pharmacy etc.;
- Encourage ambulation to facilitate socialization, and to prevent pneumonia, venous thrombosis and prevent obesity;
- Make cold compresses on the fingers that are sore, once a day;
- Help on daily living activities (DLA), such as dressing, feeding, bathing, and others (but always encourage self-care on DLA that the patient can make alone);

- Advise the patient to rise blocks, because of Captopril and Haloperidol uses, avoiding orthostatic hypotension;
- Observe the appearance of extrapyramidal symptoms due to the use of antipsychotic, as akathisia (psychomotor restlessness), dystonia (change of facial expression and abnormal body movements), tardive dyskinesia (orofacial involuntary and stereotyped movements), dyslalia (difficulty in articulating words);
- Observe other haloperidol adverse reactions: loss of visual accommodation, dry mouth, constipation, voiding difficulty caused by the blockade of muscarinic cholinergic receptors, orthostatic hypotension, appetite and obesity increase;
- Be alert to the emergence of signs and symptoms of Neuroleptic Malignant Syndrome, like unexplained fever, tachypnea, tachycardia, stiffness muscle, changes in blood pressure;
- Monitor symptoms, paying attention to the emergence of psychotic reactivation (with productive or "negative" symptoms) providing information for patient referrals in outpatient mental health;

Working from the intersectionality perspective, establishing the necessary pacts to elaboration and execution of the patient's therapeutic project

CONCLUSIONS

It's valuable to reinforce the importance of partnerships between mental health services and universities, or between nursing professionals in mental health, university professors and nursing academic students.

Works such as this study case can come from this type of partnership, enabling, thus more solving -problem discussions in care spaces and work in psychiatric nursing.

All therapeutic resources that are within should be used to decrease pain and suffering of those who are under our care. However, any care should aim not only to avoid unnecessary suffering, but also create tolerance spaces and modes of reception and living with what, in subjective life, is often of the order of inevitably painful. And, in this nuance, is accurate and necessary for professionals and nursing students approach to the subject with mental distress, and enabling, with him, learn to take care of it according to its history, with their subjective pain, with their choices, with their difficulties and their -provisional and yet so peculiar - achievements.

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